BEFORE THE APPEALS BOARD
FOR THE
KANSAS DIVISION OF WORKERS COMPENSATION

SUSAN K. CRAIN Claimant	)	
VS.	)	
AMERICAN INSULATED WIRE Respondent	)	Docket No. 255,295
AND	)	
RELIANCE NATIONAL INDEMNITY Insurance Carrier	)	

ORDER

Respondent requested review of the December 16, 2004, Award entered by Administrative Law Judge Steven J. Howard. The Board heard oral argument on June 7, 2005.

APPEARANCES

William L. Phalen, of Pittsburg, Kansas, appeared for the claimant. Stephen J. Jones, of Wichita, Kansas, appeared for respondent and its insurance carrier.

RECORD AND STIPULATIONS

The Board has considered the record and adopted the stipulations listed in the Award.

ISSUES

The Administrative Law Judge (ALJ) found that claimant sustained an accidental injury arising out of and in the course of her employment with respondent on February 2, 2000; that claimant's subsequent injury at Lamb Weston, Inc., (Lamb Weston) on or about April 16, 2001, was a direct and natural consequence of her injured knee giving out and that claimant struck her head in this fall, resulting in blindness. The ALJ further found that

as a result of her injuries, claimant is permanently and totally disabled from engaging in any substantial and gainful employment.

Respondent admits claimant suffered a work-related knee injury on February 2, 2000, and, as a result, has a permanent impairment of 16 percent to the leg. But respondent denies claimant suffered any subsequent accident or injury as a result of that knee injury. Respondent requests review of the ALJ's findings relative to the nature and extent of claimant's disability, including whether the claimant suffered a second injury and if so, whether the second injury was a direct, natural and probable consequence of the original work-related knee injury or should, instead, be treated as a separate and distinct accident. Although not mentioned in respondent's brief to the Board, during oral argument to the Board and in respondent's submission brief to the ALJ, respondent also alleged an overpayment of temporary total disability compensation (TTD) to claimant.

Claimant argues that the ALJ's Award should be affirmed in all respects.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Having reviewed the evidentiary record filed herein, the stipulations of the parties, and having considered the parties' briefs and oral arguments, the Board finds that claimant failed to prove a causal connection between the work-related knee injury of February 2, 2000, and her blindness. The Board further finds that the ratings of both Dr. Edward Prostic and Dr. Michael Poppa are credible as to claimant's right knee impairment and, therefore, claimant is entitled to an award of permanent partial disability compensation based upon an 18 percent impairment to her right leg, which is an average of the physician's ratings.

Claimant had been working for respondent only a week when she was injured in a work-related accident on February 2, 2000. Her duties included wrapping wire from a machine onto spools and taking the spools on and off the machine. Once the spool was filled, she would staple the wire to the spool to hold the wire on. The machine has a automatic shut-off mechanism when a beam of light is broken, and there is no other way to turn the machine off. On the date of the injury, claimant had been working all night. Her machine had been malfunctioning, and there was a 15-second delay before the machine would actually stop. She complained to her supervisor and told maintenance to fix the problem. At about 6 a.m., she was standing close to the spool when she heard a clanking noise and looked up to see if something was falling. All of a sudden, a wheel pulled her under and her right leg was trapped beneath the machine. She yelled for help, but no one came. Eventually she pulled herself free from the machine and crawled away. She reported the injury to her employer immediately. She was sent to the emergency room at Coffeyville Regional Medical Center, where she was given treatment, including a shot for the pain, was put on crutches, was ordered to physical therapy, and was taken off work for a period of time.

Claimant's average weekly wage at the time of her accident was $303.20. The ALJ noted that respondent's submission letter stated that claimant earned fringe benefits at the time of the accident of $71.46 per week. There is nothing in the record that indicates claimant's attorney was advised of the fringe benefit information. The ALJ added the fringe benefits to the weekly benefits to determine an average weekly wage of $374.66. However, respondent's submission brief to the ALJ also states that respondent continued to pay the fringe benefits until December 13, 2001. Accordingly, claimant's compensation rate should be based upon an average weekly wage of $303.20 until December 13, 2001, when her average weekly wage increases to $374.66.

Respondent sent claimant to see the company doctor, who claimant testified was an internist. The doctor ordered an MRI of the right knee and sent claimant to physical therapy. The company doctor referred claimant to Dr. Mohammed Shakil, an orthopedic surgeon, who performed arthroscopic surgery on claimant's right knee on March 22, 2000. When Dr. Shakil saw claimant on April 18, 2000, he found claimant was showing progress, was mobilizing weight bearing, and noted that the pain in her knee had improved. Dr. Shakil diagnosed claimant with a soft tissue injury to her knee with no disruption of any major ligaments or any fractures. Dr. Shakil wrote claimant's attorney on May 15, 2000, and stated that as of April 18, 2000, he felt claimant was capable of performing light duty work if the respondent has some available. Claimant testified that she talked to the safety supervisor about returning to work but was told there was no light duty work available.

Dr. Shakil next saw claimant on June 15, 2000, and found she had full range of flexion and extension in her right knee. Claimant, however, complained that the knee was weak and she felt it might collapse under her. Claimant testified she had never had any give-away episodes with her knee prior to her employment with respondent. Claimant was walking with an antalgic gait and there was a snapping present in the posterior aspect of the knee over the hamstring tendon which Dr. Shakil felt might be bursitis. Dr. Shakil last saw claimant on June 22, 2000, at which time she was still complaining of snapping of the medial hamstring. Dr. Shakil gave her an injection of Depo Medrol and Xylocain. Dr. Shakil's records indicate claimant was to return for observation, but there is no indication claimant ever returned. Apparently, she was neither released from treatment nor rated by Dr. Shakil.

Claimant testified she moved to Minnesota in September or October 2000. Claimant requested the ALJ order respondent to provide an authorized physician for her in Minnesota. On November 9, 2000, the ALJ ordered respondent to provide a list of three doctors for claimant to choose one.

Claimant testified that in November 2000, she suffered some kind of ischemic attack or stroke, for which she was hospitalized. At that time, she had pain down the left side of her body and could not speak. She also testified she slipped on the ice on her porch in December 2000. She testified that when she fell on her porch, she did not cause any permanent worsening of the knee. She was seen by Dr. David Benson on December 5,

2000, who thought the fall was related to her chronic knee complaint. Claimant had swelling and pain around her patella. Dr. Benson ordered claimant a knee immobilizer and prescribed analgesics. Dr. Benson indicated he would talk to workers compensation to see if an orthopedic evaluation would be approved.

Claimant was referred to Dr. Martin Benoit by Dr. Benson. Dr. Benoit first saw claimant on January 15, 2001, at which time she was on crutches and had a long knee brace. He had obtained medical records from Dr. Shakil and Dr. Prostic. Claimant complained of pain in her right knee, which she described as severe, following the slip and fall on her porch. He sent claimant to physical therapy, which claimant indicated did not help. Dr. Benoit felt she was able to perform light duty on January 15, 2001, which he noted did not make her happy. At that time she was still drawing temporary total disability benefits from respondent. Dr. Benoit saw her one other time, in February 2001, and diagnosed her with a mild patellofemoral problem, said she continued to be fit to work, and said that he thought she could return to regular work in one month.

The record shows that in February 2001, claimant was working at Burger King in Minnesota. Accordingly, claimant's entitlement to TTD ceased January 15, 2001, when she was released to light duty by Dr. Benoit. In March 2001, she quit Burger King and went to work for Lamb Weston for a higher wage.

Claimant testified that on or about April 16, 2001, Lamb Weston was getting ready for a shut down at the plant, and there was a barbecue in the cafeteria. She testified she had been working in the freezer section at the time. She took off her gear and proceeded down some stairs, and when she stepped down with her right leg, her knee gave way and she fell, striking her head. Claimant stated that although she was unconscious for a time after the fall, she did not seek medical treatment. However, on May 5, 2001, after she had experienced vision problems, claimant did go to the hospital. She testified she told the hospital about her fall down the stairs, but there is no mention of that incident nor of any significant head trauma in the hospital records. She was transferred from the small hospital at Park Rapids to North County Regional Hospital in Bemidji, Minnesota, where she was seen in the emergency room and then transferred again to MeritCare Hospital in Fargo, North Dakota. Records from Dr. Steven Thom of MeritCare Hospital indicated that claimant had a possible bilateral optic neuritis with at least an underlying small component and possibly a large component of either malingering or hysteria.

Claimant testified that she started having vision problems about two or three days after her fall at Lamb-Weston, and she is now 100 percent blind. She has a seeing eye dog and wears dark glasses because if a really bright light shines in her left eye, it gives her a headache.

Claimant filed a workers' compensation claim in Minnesota against Lamb Weston but said she did not follow through on that claim. The State of Minnesota Notice of

Insurer's Primary Liability Determination indicates that liability for claimant's claim was denied because

> [t]he employee and her attorney did not provide timely notice to this employer per the statutes and have not even specified the nature of the alleged injury. Also, in light of previous statements made to the employer, the incident is not credible. The employee is put to her strict proof that any injury or condition arose out of or within the course or scope of her employment.[1]

After claimant became blind, she moved to the Kansas City area and began treatment with Dr. Mark Hartley. Dr. Hartley ordered another MRI and performed a lateral release surgery on her right knee. Dr. Hartley released her from treatment in October 2002. Currently, she still has constant pain in her right knee, and the knee still moves when walking either up or down stairs. Claimant testified that neither the surgery performed by Dr. Shakil nor by Dr. Hartley helped at all; she is still having the same problems with her knee she has had since the initial injury.

On August 3, 2002, claimant was admitted to a hospital in Kansas City for a possible heart attack. Her symptoms included pain in her left arm.

Claimant was first seen by Dr. Prostic on July 24, 2000, at the request of claimant's attorney. Dr. Prostic is a board certified orthopedic surgeon. Claimant gave a history of a work-related accident in which her leg was caught by a wire with twisting of her right knee. Claimant stated she was taken to the hospital, where she was seen by Dr. Ervin Howell, and a knee immobilizer was applied. Dr. Howell diagnosed a strain. Claimant was then seen by Dr. Shakil. An MRI was performed that failed to show a meniscal lesion. Physical therapy was provided, and when claimant failed to improve, she was operated on by Dr. Shakil. Claimant denied previous difficulties with her right leg. At the time claimant saw Dr. Prostic, she was complaining of pain in the front of her right knee and snapping at the back of the knee. She had stiffness when she awoke and after sitting. She had difficulty standing more than 15 to 20 minutes or walking beyond one and a half blocks. She had difficulty going up and down stairs and could not squat, kneel, run, jump or dance. She had clicking, popping and giving away of the knee and was sensitive to inclement weather.

Dr. Prostic's physical examination indicated that claimant had a very deliberate gait. When asked to walk on her toes or heels, she developed an antalgic gait favoring the right leg. The alignment of her lower right extremity was satisfactory. There was no heat, swelling or erythema noted. There was a one half inch decrease in circumference of the right thigh as compared to the left four inches above the superior pole of the patella. No intraarticular effusion was noted. There was severe tenderness of the patellofemoral joint.

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[1]R.H. Trans., Resp. Ex. 1 at 5.

Range of motion was complete, and no instability was noted. There was abnormal quadriceps angle. Neither patellar crepitus nor popping were noted. McMurray's maneuver was negative. Claimant complained more with compression during the Apley maneuver than with distraction. X-rays were taken, and the only abnormality noted was asymmetry of the patella with mild lateral facet overhand. Dr. Prostic testified that the results of the physical examination were consistent with claimant's complaints. Dr. Prostic's diagnosis was severe patellofemoral dysfunction caused by the injury at respondent on February 2, 2000.

Dr. Prostic saw claimant again on October 1, 2001. Claimant advised Dr. Prostic that surgery had been performed on her knee for subluxation of her patella and lateral retinacular release. Claimant advised that she had been prescribed physical therapy and given a release to return to full duties by Dr. Shakil. Claimant also described a fall at Lamb Weston, which purportedly resulted in the loss of her eyesight.

Dr. Prostic testified that the February 2, 2000, injury suffered by claimant while working for respondent could have caused give-away sensations in the knee. He explained that as the patella slips laterally, there is often a loss of control of the leg. Dr. Prostic's physical examination of claimant showed claimant had a healed midline scar over the patella. She had prominence of the infrapatellar fat pad. There was markedly valgus quadriceps angle and hypermobility of the patella, especially medially. There was tenderness of the patellofemoral joint with minimal crepitus. Range of motions showed reluctant flexion, but claimant was able to flex almost completely. Meniscal signs were negative, and no instability was noted. Dr. Prostic's diagnosis remained recurrent subluxation of the patella.

Dr. Prostic recommended quadriceps realignment surgery, patella bracing, hamstring stretching, quadriceps strengthening, anti-inflammatory medicine, and consideration of a long leg brace with drop locks at the knee.

Dr. Prostic next saw claimant on March 17, 2003. The updated history he took from claimant indicated an MRI was performed of her knee and was unremarkable. Claimant had been operated on by Dr. Hartley for chondroplasty of the patella, given exercises, and was released from his care in October 2002. Dr. Prostic's physical examination of claimant found a very prominent infrapatellar fat pad with scars from arthroscopic punctures, as well as a short medial patella scar. There was moderately abnormal quadriceps angle and poor development of the vastus medialis obliquus muscle and tenderness of the patellofemoral joint with mild crepitus. The remainder of the examination was satisfactory. Dr. Prostic's diagnosis remained recurrent patella subluxation.

Based on the AMA *Guides*[2], Dr. Prostic opined that claimant had sustained a 20 percent permanent partial impairment of the right leg. Dr. Prostic also opined, assuming claimant has a 100 percent impairment of her visual system, that it was unrealistic for claimant to be employed in the general labor market, and she is permanently and totally disabled from any substantial gainful employment.

On cross-examination, Dr. Prostic testified that claimant has a genetic predisposition to her knee problem. The work-related injury while employed with respondent aggravated that preexisting condition and caused it to become symptomatic.

On February 21, 2003, claimant was seen by Dr. Rolfe Allen Becker, a board certified ophthalmologist, at the request of claimant's attorney. Claimant gave a history of falling at Lamb Weston, hitting the back of her head, and losing consciousness. Upon recovering consciousness, she noticed visual phenomenon, S-shaped items, splotches and missing letters, and she developed headaches. Claimant told Dr. Becker that approximately two weeks after the slip and fall at Lamb Weston, she awoke one morning and could no longer see. Claimant had not seen a doctor after the fall until her complete loss of eyesight, at which time she went to the emergency room and was admitted. She gave Dr. Becker a history of a stroke in 2000. Upon examination of claimant, Dr. Becker found no light perception in either eye. The only abnormal finding in claimant's eye examination was the lack of light perception. The optic nerve looked to be healthy, which told Dr. Becker that the eyeball itself was intact and functional.

Dr. Becker's opinion was that the total loss of claimant vision was caused by some damage to the visual cortex, the part of the brain which interprets vision, which is in the back of the brain in the cortical portion of the brain. His diagnosis of claimant was coritical blindness. Cortical blindness could be caused by a closed-head injury to the back of the head. Dr. Becker stated that in his medical opinion, claimant's fall down the stairs and hitting her head was the cause of her vision loss. Using the AMA *Guides*, Dr. Becker gave claimant a 100 percent impairment of the visual system and 85 percent impairment for the whole person.

On cross-examination, Dr. Becker stated he did not have any medical records to review at the time of the examination, nor had he reviewed any records since his examination. Dr. Becker acknowledged that his opinion depended entirely on the history given to him by claimant and that his opinion was only as good as the history he had been given. Dr. Becker stated that the brain, while protected, could be damaged if it shifts around and is hit hard enough or at a certain angle. This could produce swelling in the brain that is slow to evolve and would create problems inside the skull. Dr. Becker stated that it would have to be a fairly significant injury to cause swelling. In reviewing the hospital

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[2]American Medical Association, *Guides to the Evaluation of Permanent Impairment* (4th ed.). All references are based upon the fourth edition of the *Guides* unless otherwise noted.

records of claimant, Dr. Becker admitted that none of them mentioned a history of a fall or head injury. He further admitted that there was nothing in the MRI performed May 6, 2001, at MeritCare Hospital to indicate that claimant had suffered a traumatic head injury.

When asked whether a minor stroke could cause a burst blood vessel to cause pressure in the cortex, Dr. Becker stated that it could. Also, claimant's complaints of headache and visual spots are consistent with migraines.

Dr. Michael J. Poppa is a doctor of osteopathic medicine who is board certified in occupational and preventative medicine and practices full time as a treating physician in occupational medicine. Dr. Poppa examined claimant on April 6, 2004, at the request of respondent's insurance carrier. Dr. Poppa examined claimant's knee. His examination revealed normal reflexes of her lower extremities, including her left patella/achilles and right achilles. Her right patellar reflex was not tested secondary to previous knee surgery. Active range of motion of claimant's right knee was measured at 90 degrees of flexion and zero degrees of extension with associated complaints. Claimant complained of tenderness on palpation involving her right patella. Claimant ambulated with a right knee support and had an antalgic gait, which Dr. Poppa assumed was secondary to claimant's stroke and knee surgery. Dr. Poppa had no records relative to claimant's prior stroke and obtained the information by taking an oral history from her.

Dr. Poppa testified that claimant had a 16 percent impairment of her right lower extremity based on AMA *Guides*. Dr. Poppa also testified that claimant was not a candidate for additional surgical procedures involving her knee and required no additional formal medical care or treatment. Dr. Poppa diagnosed claimant's blindness as optic neuritis and opined that claimant's blindness was neither causally nor directly related to her employment or work-related injury at respondent because optic neuritis is not related to trauma. He further noted that there was no support for a traumatic head injury in the medical records.

Dr. Michael E. Hettinger is board certified in ophthalmology. He examined claimant on May 7, 2004, at the request of the respondent. Prior to his examination of claimant, he reviewed claimant's medical records from Minnesota and North Dakota. Dr. Hettinger testified that an MRI taken of claimant's head at that time was normal, and there was nothing in the records to support a finding that claimant had sustained a fall. Dr. Hettinger testified that claimant had no signs of optic neuritis. He testified that for there to be no light perception out of either eye, there would have had to have been some kind of massive damage to the entire occipital cortex or something in the path from the eye to the occipital cortex. So that he could determine if such damage was present, he ordered a visual evoked potential (VEP) test and an electroretinogram test, which were both normal. Dr. Hettinger found no physical reason why claimant had no light perception or could not see and could not relate her blindness to any physical or traumatic incident. He related her blindness to hysterical conversion reaction, which occurs when someone sees or experiences something so traumatic, emotionally, physically or both, that they cannot see.

Her brain is suppressing what she is seeing. He did not know the reason for this suppression but said the blindness is real to the claimant.

Julie Larson, the human relations manager at Lamb Weston, testified that claimant was employed at Lamb Weston beginning March 28, 2001. Ms. Larson testified that Lamb Weston received a letter from claimant's attorney stating claimant was making a workers compensation claim alleging a date of accident on or about April 16, 2001. Claimant alleged she had suffered a head injury while working in the freezer section of Lamb Weston. Upon receipt of the letter from claimant's attorney, Ms. Larson reviewed claimant's personnel file and found no information indicating claimant had suffered an accident at Lamb-Weston. On April 13, 2001, the day before the scheduled shut-down, claimant was scheduled to clean in a packaging area, which was not near the freezers. Ms. Larson was not sure where claimant was working, but wherever it was would have been around a set of stairs. Claimant's last day of work for Lamb Weston was May 2, 2001.

Lamb Weston received a call on May 5, 2001, indicating that claimant had gone to the hospital because of vision problems. Claimant also talked with Nicky Nater of the human relations department on May 18, 2001, but she did not indicate to him that she had fallen at Lamb Weston.

Ms. Larson testified that on May 22, 2001, claimant called Lamb Weston and advised she would not be returning to work until after her next doctor's appointment, which was to be May 29, 2001. Lamb Weston never heard from her after that until they received the notification from her attorney that she was filing a workers compensation claim. Lamb Weston conducted an investigation concerning claimant's alleged work injury. Ms. Larson spoke with everyone in the human relations department, the sanitation specialist, and all claimant's supervisors, and determined that claimant had not reported an accident to any of them.

The Board finds that claimant has failed to prove a direct causal connection between her alleged blindness and the February 2, 2000, work-related accident with respondent. The Board further finds that claimant has failed to prove that she suffered a head injury on or about April 16, 2001, while employed at Lamb Weston or that any such head injury was the result of a give away incident involving her right knee condition. Claimant failed to report any such accident or injury to her employer in April 2001. Furthermore, when claimant sought medical treatment in May 2001, she failed to mention such an accident, head injury or period of unconsciousness. The testing performed at Innovis Hospital, MeritCare Hospital and North County Regional Hospital in May 2001 fail to disclose a traumatic closed head injury, fluid or swelling, in or around the brain. In particular, the MRI and CT scans were negative for any head injury or contusion to the cerebral cortex. Finally, the optical nerve tests performed at the behest of Dr. Hettinger likewise indicated that there was no damage to either the optic nerve or the cerebral cortex. Dr. Becker did not have the benefit of the VEP and electroretinogram testing results when

he examined claimant. Furthermore, Dr. Becker was not provided with the claimant's medical records at the time of his examination. The fact that he refused to question his diagnosis in the face of evidence that contradicted claimant's history to him is perplexing. The Board finds the expert opinion testimony of Dr. Hettinger to be more credible and persuasive than that of Dr. Becker. Accordingly, compensation for claimant's work-related injury should be limited to the right knee.

AWARD

WHEREFORE, the Award of Administrative Law Judge Steven J. Howard dated December 16, 2004, is modified as follows: Claimant sustained an 18 percent permanent partial disability to her right leg and is entitled to 49.71 weeks of temporary total disability compensation at the rate of $202.14 per week in the amount of $10,048.38 followed by 27.05 weeks of permanent partial disability compensation, at the rate of $202.14 per week, in the amount of $5,467.89 for a 18 percent loss of use of the leg, making a total award of $15,516.27, all of which is due and ordered paid in one lump sum less amounts previously paid.

Respondent and its insurance carrier shall pay for all of the medical treatment related to claimant's February 2, 2000, accident and right knee injury, subject to the Medical Fee Schedule. Respondent and its insurance carrier are not liable for treatment for claimant's other, unrelated medical and psychiatric/psychological conditions, including the alleged accident and injury of April 16, 2001, and the alleged blindness condition.

IT IS SO ORDERED.

Dated this _____ day of October, 2005.

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BOARD MEMBER

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BOARD MEMBER

_____
BOARD MEMBER

c: William L. Phalen, Attorney for Claimant
Stephen J. Jones, Attorney for Respondent and its Insurance Carrier
Steven J. Howard, Administrative Law Judge
Paula S. Greathouse, Workers Compensation Director